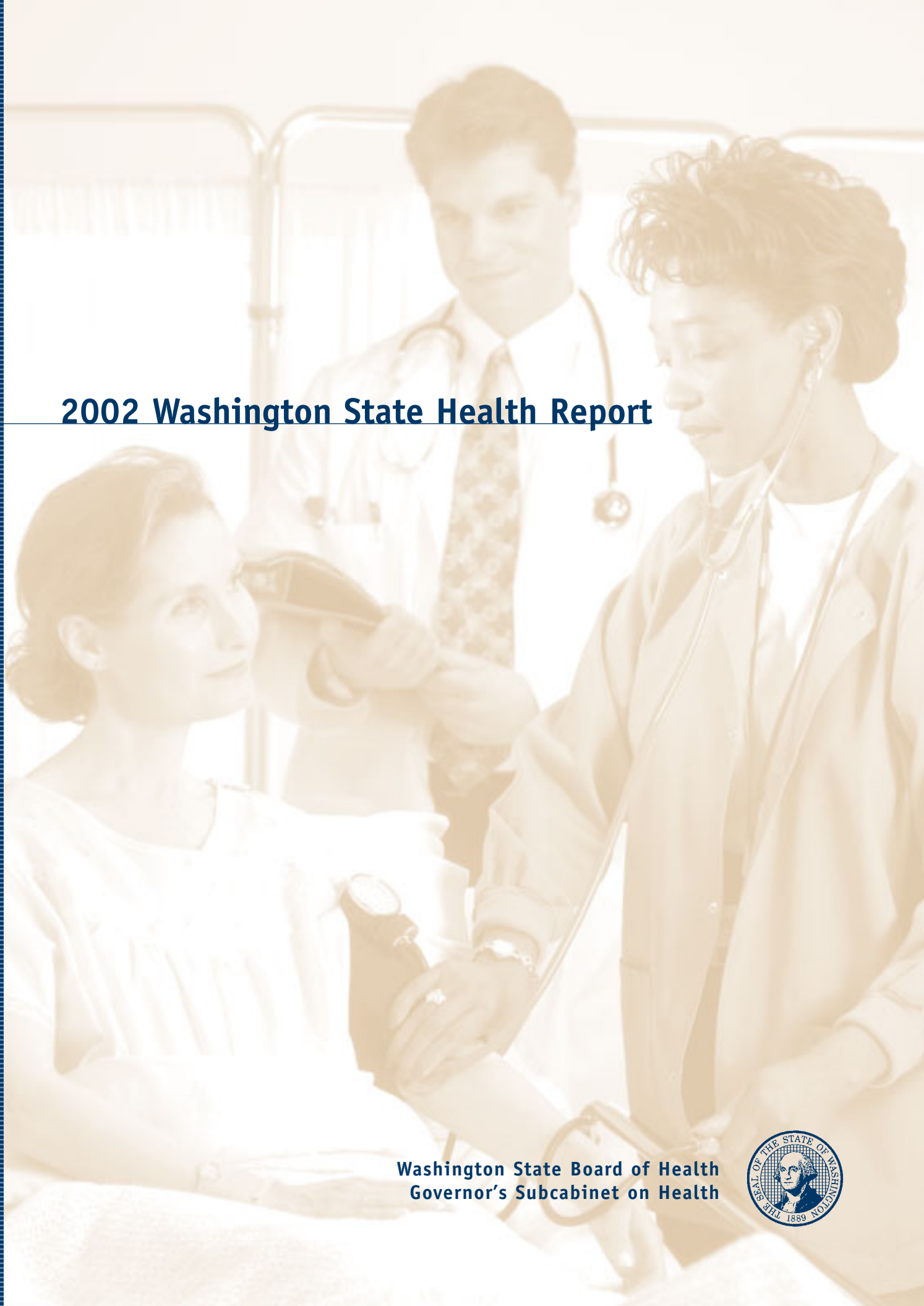

2002 Washington State Health Report

Washington State Board of Health
Governor's Subcabinet on Health

GARY LOCKE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 753-6780 • www.governor.wa.gov

May 6, 2002

Washington State Board of Health and
the Governor's Subcabinet on Health
P.O. Box 47990
Olympia, WA 98504-7990

Ladies and Gentlemen:

It was a pleasure to meet with representatives of the State Board of Health and Governor's Subcabinet on Health last week. I am returning herewith, with my approval, the 2002 Washington State Health Report.

RCW 43.20.50(1)(b) provides that the State Board of Health shall prepare a report in January of every even-numbered year "that outlines the health priorities of the ensuing biennium." It further stipulates that I must approve, modify, or disapprove the report.

This report clearly articulates the key challenges and opportunities facing state health care agencies and suggests five strategic directions for state health policy:

- maintain and improve access to critical health services;
- improve patient safety and increase value in government-purchased health services;
- bolster the health system's capacity to respond to public health emergencies;
- reduce disproportionate disease burdens among racial and ethnic minority populations; and
- encourage responsible behavior to reduce tobacco use, improve nutrition, and increase physical activities.

I appreciate your collaborative efforts on this document. It will be a useful tool for my office and agency directors as we prepare budgets and request legislation for the 2003-05 biennium.

Sincerely,

Gary Locke
Governor

February 15, 2002

The Honorable Gary Locke
Governor of Washington
Legislative Building
Olympia, WA 98504

Dear Governor Locke:

We are pleased to forward to you the proposed *2002 Washington State Health Report* for your consideration and possible approval.

Since 1990, the Washington State Board of Health has been responsible for producing a biennial State Health Report "that outlines the health priorities of the ensuing biennium." RCW 43.20.50(1)(b) stipulates that the report be produced in January of even numbered years and that it serve as an aid to you in beginning the budget process. It further stipulates that you must approve, modify, or disapprove the report. If approved, the report is to be used by state agency administrators as a guide for preparing agency budgets and executive request legislation—in this case, for the 2003-2005 biennium.

This is the sixth State Health Report and the first that is a collaboration between the Board and representatives of the Governor's Subcabinet on Health. It draws on a wide variety of research and policy development efforts to suggest five strategic directions for state health policy:

- Maintain and improve access to critical health services
- Improve patient safety and increase value in government-purchased health services
- Bolster the health system's capacity to respond to public health emergencies
- Reduce disproportionate disease burdens among racial and ethnic minority populations
- Encourage responsible behavior to reduce tobacco use, improve nutrition, and increase physical activity

These strategic directions are just that—they are not intended to be all-encompassing or restrictive. The report contains a summary of why each strategic direction is included, a "for instance" that describes one example of an initiative deserving further consideration, and a list of possible actions that illustrate the scope of the strategic direction. It does not attempt to enumerate action strategies for the 2003-05 biennium. The Board and Subcabinet representatives concur that decisions about specific health programs should be made by agency heads coordinating their efforts through the Subcabinet. It is our belief that a brief, strategically focused report will ultimately prove most useful.

The Board and Subcabinet recognize the significant challenges facing public health, health care, and the delivery of government services. It is our hope that identifying a specific, limited set of strategic directions can inform agency actions and help the state make Washington a safer and healthier place for all residents.

Sincerely,

Ida Zodrow, Chair
Governor's Subcabinet on Health

Linda Lake, Chair
Washington State Board of Health

Introduction

The Washington State Board of Health is responsible for producing a State Health Report "that outlines the health priorities of the ensuing biennium." RCW 43.20.50(1)(b) stipulates that the report be produced in January of even numbered years and serve as an aid to the governor and agency directors during the budget process. The 2002 report is a collaboration between the Board and representatives of the Governor's Subcabinet on Health. See the Background section, page 14, for a description of the process that led to this report.

The Role of State Government

State government's health responsibilities grow from our State Constitution's commitment to provide for the public health and welfare and care for our most vulnerable populations (Article XIII, Section 1), and to regulate medicine and pharmacy (Article XX, Section 2). The Legislature has interpreted these duties to entail:

Maintaining and Improving Public Health

- Keeping records of births and deaths and monitoring patterns of illness and disease
- Acting swiftly and effectively to control the spread of communicable diseases
- Reducing preventable diseases and injuries
- Protecting the safety of our food, water, and air
- Safeguarding the health of vulnerable populations by assuring that residents have access to health services critical to their ability to lead healthy, independent, and productive lives
- Preventing injury and disability within the workforce in the state

Purchasing Health Services

- Purchasing health services for the poor, dependent children, the disabled, the elderly, injured workers, prisoners and public employees
- Ensuring that these public investments return the greatest possible value for our state's taxpayers by working constantly to contain the costs and improve the quality of these health services

Regulating Health Facilities, Health Providers, and the Health Insurance Industry

- Ensuring that health care professionals and health facilities meet minimum safety standards and encouraging them to strive for the highest level of quality
- Ensuring that health insurers remain solvent to meet their commitments to their policy holders and that the private insurance market operates fairly and equitably for our state's health insurance consumers

Strategic Policy Directions for 2003-05

State government must periodically re-examine these duties and strategically focus resources to improve the health of citizens, to respond to new health threats, to take advantage of new health discoveries, and to live within the ever-changing financial and social realities of our state and nation.

Our strategic health policy directions for 2003-2005 are:

- Maintain and improve access to critical health services
- Improve patient safety and increase value in government-purchased health services
- Bolster the health system's capacity to respond to public health emergencies
- Reduce disproportionate disease burdens among racial and ethnic minority populations
- Encourage responsible behavior to reduce tobacco use, improve nutrition, and increase physical activity

Maintain and improve access to critical health services

Summary

Access to quality, affordable health care is a major indicator of health—both nationally and in Washington State.

Multiple studies, reports, and articles show that the state and national health care systems are in need of change. Access to care and quality of care need to be protected and improved. The Institute of Medicine report *Crossing the Quality Chasm, A New Health System for the 21st Century* states that as medical science and technology have advanced, the health care delivery system has lost ground in its efforts to provide consistent, quality care to all Americans.

Factors that limit access to care include: lack of insurance, lack of a regular place of care (a "medical home"), and a variety of financial, structural, and personal barriers. Health care costs are rising dramatically, the number of providers appears to be shrinking, and many people are finding health insurance increasingly difficult to obtain or afford. These factors suggest that access to care is likely to be a growing problem in Washington State.

One area of concern is residents without health insurance. According to preliminary data from the Washington State Planning Grant on Access to Health Insurance, 8.3 percent of the state population lacks health insurance. The state's three-year average rate for 1998-2000 was lower than the national three-year average. There are several subpopulations, however, for which the uninsured rate is 19 percent or higher: 19- to 24-year-olds, members of households making less than $35,000 per year, Hispanics, and American Indians/Alaska Natives.

The number of uninsured in Washington State has declined because of expansion of government programs and businesses competing for employees in a tight labor market. This decline is not likely to continue in the short term. The state is looking to offset a revenue shortfall on the order of $1.25 billion by reducing spending and the labor market is no longer as competitive as it was, given the nationwide recession and rising unemployment rates.

Uninsured adults are 30 percent less likely to have had a checkup in the last year and 40 percent more likely to have skipped a recommended treatment or test than insured adults, according to the Kaiser Commission on Medicaid and the Uninsured. They are more likely to forgo preventive care, require hospitalization for avoidable conditions, die during hospitalization, and be diagnosed with cancer during late stages of the disease.

Access difficulties are not limited to the uninsured—or even the growing number of underinsured. Research by the Southwest Washington Health District, for example, found that residents with insurance were having difficulties obtaining timely care even with insurance, due primarily to provider shortages. *Who Will Care for You?*, a recent Washington State Hospital Association report, identified many shortage areas and noted, "During the past year, 55 percent of hospitals in Washington state went on 'divert status' due to a shortage of nursing staff." Shortages are particularly acute in rural areas, in communities of color, for key professions (pharmacists, nurses, etc.), and for providers willing to accept patients on Medicare and Medicaid.

A 1997 statewide public opinion survey by the State Board of Health asked respondents to name the most important health area on which government should work. The greatest number, 22 percent, said access to health care. When asked about the seriousness of various health issues, the greatest number, 79 percent, said state government should give access to health care a high or very high priority.

During its 2001 research, the Board found extensive support in the literature for making access a top priority. Additionally, key informants interviewed as part of this research frequently mentioned access as one of the biggest issues facing the state.

A 'For Instance'

Enhanced Delivery of Minimal Clinical Preventive Services

According to the Washington State Health Agency Medical Directors (AMD) and the Board's own research, there is broad agreement on the clinical preventive services that should be offered to children and adults.

Several state health care programs rely on the United States Preventive Services Task Force *Guide to Clinical Preventive Services*; the Department of Social and Health Services Medical Assistance Administration uses the federally mandated Early Periodic Screening, Diagnosis, and Treatment (EPSDT) standard for children; and the Board has developed a list of recommended "Children's Clinical Preventive Services." These evidence-based standards are largely consistent.

There is less agreement as to whether these services should be delivered uniformly or selectively based on a provider's clinical judgment. Notwithstanding this disagreement, there are concerns that current practice does not pay adequate attention to the delivery of clinical preventive services. Therefore, the AMD recommends that state agencies explore the effectiveness of mechanisms for measuring and monitoring the appropriate delivery of preventive services.

Specifically, AMD recommends reviewing the effectiveness of all preventive measures, comparing existing state requirements against the experiences of other states, defining a minimum set of clinical preventive services, requiring minimal clinical services in contract language, and evaluating the effects of contract provisions on utilization and outcomes.

This work would begin with children's services during the remainder of the 2001-03 biennium and could be extended to adult services in 2003-05.

Other Possible Actions

- **State Planning Grant:** The state intends to seek an extension to a $1.3 million, one-year federal planning grant to profile the state's medically uninsured and identify ways to address gaps in access to health insurance and care. The emphasis for 2003-05 might include implementing top interventions identified by later phases of the project.

- **Targeted Reimbursements:** Provide targeted fee increases for specific providers whose services are in scarcest supply (e.g., primary care physicians, child psychologists) to improve access for Medical Assistance clients.

- **Public Health Improvement Partnership (PHIP):** Continue efforts to implement PHIP standards by encouraging local health jurisdictions and the Department of Health to measure access to critical health services and mobilize community efforts to close identified gaps.

- **Clinical Services for Children:** Explore school-entry requirements and other avenues for ensuring children have access to well-child checkups and associated preventive care.

- **Restructure Public Benefits Plans:** Explore ways to use the evidence-based "Menu of Critical Health Services" developed by the Board as a starting point for restructuring benefits in the Basic Health Plan, Public Employee Benefits Board plans, and Medical Assistance Administration programs, using any savings to expand eligibility.

Improve patient safety and increase value in government-purchased health services

Summary

Americans spent 13.2 percent of the gross national product on health care in 2000, according to the Centers for Medicare and Medicaid Services. Health care, not housing, is now the biggest purchase most of us will make in our lifetime. Compared to other industrialized nations, however, we are losing ground when it comes to infant mortality and life expectancy.

It is not always best to buy the cheapest product. We commonly consider quality when purchasing a car, yet rarely factor quality into medical purchasing. The Institution of Medicine Report *To Err Is Human: Building a Safer Health System* found that medical mistakes cause between 44,000 and 98,000 deaths each year—more than HIV/AIDS, breast cancer, or vehicle accidents. It estimated the annual costs of these preventable errors at $17 and $27 billion. A follow-up report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, called for an overhaul of health care to increase quality and safety.

Government is the primary funder of health care in the United States, according to data from the Employee Benefit Research Institute and other sources. A major share of government health expenditures comes from state funds and federal funds administered by states. It is not surprising, therefore, that health care is considered the most critical cost driver for state government.

As a major purchaser of health care services, Washington State is committed to obtaining value—and defines value as quality divided by price. Cost-containment is only one piece of the health care purchasing puzzle. The state recognizes that it can improve value by improving efficiency in contracting and purchasing *and* by improving patient safety and overall quality of care.

In 1999, the 50 states spent $238.5 billion on personal health care, which represented 27.1 percent of state spending. Of that, 73 percent was spent for Medicaid, 7.9 percent for employee health benefits, 6.3 percent for community-based services, 5.5 percent for public health, 3.1 percent for state-run health care facilities, and the rest for a mix of health care for students in higher education, incarcerated populations, children enrolled in the State Children's Health Insurance Program (SCHIP), and other participants in state-sponsored efforts to improve access to insurance and care (e.g., Washington State's Basic Health Plan).

Medicaid, the Basic Health Plan, and other state programs insure more than 15 percent of Washington residents. The Public Employee Benefits Board covers approximately 300,000 state employees, retirees, and their dependents—or roughly 5 percent of the population. The Medical Assistance Administration covers more than 850,000 people in the state.

According to the *2001 Pulse Indicators* being prepared by the University of Washington Health Policy Analysis Program, 43 percent of the state's 2001-03 budget will go to health expenditures (this includes federal funds appropriated by the state for programs such as Medicaid).

Health care costs have been growing at a rate that far outstrips inflation. National estimates of increases vary, but a survey of employers released in December 2001 by the William M. Mercer consulting firm found the cost of covering each employee rose 11.2 percent in 2001, and is expected to increase another 12.7 percent in 2002. In 2000, the Washington State Health Care Authority (HCA) experienced increases of 8.8 to 16.4 percent for the Basic Health Plan and for state employee health coverage, according to HCA's 1999 Annual Report. Spending per Medicaid enrollee is currently believed to be growing by more than 10 percent a year, according to the Kaiser Commission on Medicaid and the Uninsured. Factors contributing to escalating health care costs include: prescription drug costs, increased utilization, increased consumer demand, medical advances that provide treatments for a growing number of conditions, and wage pressures in the health care industry.

A 'For Instance'

Consolidated Purchasing and Management of Pharmacy Benefits

Escalating expenditures for pharmaceuticals—attributable to increased utilization, newer, more expensive products, and price increases—is a major driver of state health care costs.

A 2001-03 biennial budget proviso calls on the Department of Social and Health Services (DSHS) to implement cost containment and utilization strategies that would reduce general fund costs by 3 percent below projected levels. As part of the effort to meet this mandate, DSHS will implement the Therapeutic Consultation Service in January 2002. The program seeks to ensure the appropriate, cost-effective use of prescription drugs by Medicaid clients. Clinical pharmacists will review selected clients' drug profiles and consult with their providers to promote the most effective drug therapies.

Similarly, the Governor's proposed 2002 supplemental budget suggests the Washington State Health Care Authority (HCA) be authorized to put in place fair and equitable strategies to reduce prescription drug expenditures by 15 percent.

The Prescription Drug Project, an interagency work group, has recommended a comprehensive program that includes a statewide Pharmacy and Therapeutics Committee, a statewide Preferred Drug List, and consolidated pharmacy management and information services. When implemented, the program will ensure patients have access to rational, clinically appropriate, safe, and cost-effective therapy while supporting an affordable and sustainable drug benefit program.

These and other efforts to control expenditures related to increasing costs and utilization of prescription drugs are likely to continue through the 2003-05 biennium.

Other Possible Actions

- **Medicaid Reform:** DSHS has applied for a waiver that would allow it to sustain subsidies for low-income health care by covering parents of children enrolled in Basic Health and SCHIP and by adopting premiums, copayments, and new benefits packages. Implementation will extend into 2003-05.

- **Value-Based Purchasing:** HCA has begun evaluating health plan using scores and metrics that include access, quality, and affordability. These allow HCA to understand how the plans perform in customer service, basic prevention activities, and administrative processes. The information is used in contracting and is available for all covered members.

- **Demand Improvement:** Improve quality by encouraging consumer choices that improve outcomes, reduce costs, or both—often by addressing the overuse, misuse, or underuse of procedures or drugs. The AMD has recommended pilots, such as addressing excessive or ineffective use of antibiotics.

- **Disease State Management:** Coordinate efforts to provide systematic, cost-effective care to people with complex and sometimes progressive disorders, particularly chronic conditions (e.g., diabetes).

- **Administrative Simplification:** Contain costs, reduce provider burdens, improve service, and comply with the Health Insurance Portability and Accountability Act by establishing standards for administrative practices. One example would be single-source credentialing of practitioners.

- **Patient Safety:** Try to reduce adverse events and medication errors by identifying specific, critical patient-centered outcomes that can be measured to track quality of care and better inform consumers.

- **Technology Assessment:** Develop a more systematic or centralized system for making evidenced-based decisions about when to employ new medical technologies.

Bolster the health system's capacity to respond to public health emergencies

Summary

When introducing the Frist-Kennedy Public Health Threats and Emergency Act of 2000, Senator Edward Kennedy called new and re-emerging diseases, anti-biotic-resistant microbes, and bioterrorism the "Three Horsemen of the Modern Apocalypse." He added:

> **"Today we face a world where deadly contagious diseases that erupt in one part of the world can be transported across the globe with the speed of a jet aircraft. The recent outbreak of West Nile Fever in the New York area is an ominous warning of future dangers. Diseases such as cholera, typhoid and pneumonia that we have fought for generations still claim millions of lives across the world and will pose increasing danger to this country in years to come. New plagues, like Ebola virus, Lassa Fever and others now unknown to science may one day invade our shores."**

Whether the disaster is a naturally occurring disease outbreak, a mass trauma event along the lines of the September 11 tragedy, a natural disaster, or the use of weapons of mass destruction by terrorists or conventional militaries, the first response to a health emergency will come from the local and state level.

Many experts and organizations have called for a more "robust" public health system in response to possible bioterrorism threats. They note that public health programs and activities needed to respond to a bioterrorism attack—disease surveillance, laboratory testing, risk communication, vaccine distribution, public education, environmental monitoring, and more—are the very programs public health uses quietly every day to create a safer and healthier nation.

Last year, the Centers for Disease Control and Prevention (CDC) asked itself, in response to a congressional inquiry, "is public health's infrastructure up to the task, prepared for the global health threats of the 21st century?" It concluded, "Unfortunately, the answer is no." A host of studies, expert pronouncements, assessments, field exercises, and real-world events support the CDC's conclusion.

Washington State is regarded among public health professionals as having a high-performing network of state, academic, and local public health agencies. When it comes to preparing for bioterrorism and other major disease outbreaks, it is ahead of most other states. The response of the Department of Health, the Governor's Office, the Emergency Management Division, and other state entities in the wake of September 11 was exemplary. The state, however, is part of the national infrastructure and shares both its strengths and its weaknesses.

In 2000, the Department of Health, as part of a joint Department of Justice and CDC nationwide effort, conducted a Public Health Emergency Preparedness Assessment. It asked the 39 counties to answer a series of questions based on the Draft Public Health Emergency Standards. "In general," the Department concluded, "Washington's local public health systems are not adequately prepared for a major biological emergency."

Concerns are not limited to public health; they also extend to the health care delivery system. A U.S. Health and Human Services survey of emergency departments at all hospitals in Washington, Oregon, Idaho, and Alaska attempted to assess whether hospitals are prepared to respond to chemical or biological attacks. The researchers concluded that emergency departments are generally not prepared to respond to a biological or chemical weapons attack .

One area of concern in Washington State is the surge capacity of the health care system. In recent years, cost and profitability concerns have squeezed excess capacity out of the system—but during times of health emergencies, excess capacity can become surge capacity that is necessary to mount an adequate response to a major disease outbreak or mass casualty event.

A 'For Instance'

Adequate State, Federal Funding for a Robust Public Health System

In November 2001, the Board adopted *Response Capacity During a Health Emergency—A Review of Selected Issues*. The report made nine recommendations, most of which concerned the need to increase the capacity of the public health system by promoting adequate government funding.

Since the potential threats from bioterrorism, new and re-emerging diseases, and antibiotic-resistant microbes are unlikely to diminish significantly in the short-term, consideration of these recommendations is likely to be critical during the preparation of the 2003-05 biennial budget.

Other Possible Actions

- **Education and Training:** Expand and improve training for medical personnel in how to identify and report symptoms of biological weapons exposure, and for public health professionals to rapidly evaluate and respond to potential disease outbreaks. Strategies could include funding continuing medical education; working with education institutions to expand offerings; collaborating with professional associations to disseminate courses; distributing trainings over the state network; and mandating training.

- **Syndromic Surveillance:** Explore implementation of systems to detect and rapidly investigate illness clusters and critical clinical syndromes such as respiratory problems and diarrhea. Study existing syndromic surveillance systems; evaluate their effectiveness and use; and develop pilot systems in target population centers around the state.

- **Regional Pharmaceutical Stockpile:** As an individual state or as part of a regional compact, establish a backup to the federal pharmaceutical stockpile in easily accessed locations near transportation hubs. Analyze pharmaceutical supplies and distribution mechanisms in the Northwest; identify pharmaceuticals most appropriate for a regional stockpile; and determine the best mechanism for implementing and maintaining a stockpile.

- **Reporting and Communication Systems:** Enhance and expand existing electronic reporting and communication systems to include all local and state agencies with a role in emergency response, all hospitals, and key health care providers.

- **Surge Capacity:** Improve capacity at local health agencies, DOH, laboratories, and health care facilities to respond to mass casualty events by assessing current capacity; estimating resources needed in each community; developing community or regional strategies; and deploying resources to provide surge capacity as identified in community or regional plans.

Reduce disproportionate disease burdens among racial and ethnic minority populations

Summary

Healthy People 2010, the federal strategic health plan, identifies only two major goals for improving the nation's health in the next decade—and one is to reduce health disparities (the other is to increase quality and years of healthy life). *Health disparities* is a term that describes a disproportionate burden of disease, disability, and death among a particular population or group.

Racial and ethnic minorities make up roughly one-fifth (18 percent) of Washington State's population. Yet their disease burden is significantly higher. In Washington State, according to the Board's *2001 Final Report on Health Disparities*:

- The infant mortality rate for American Indians and African Americans is more than double the rate for Caucasians.
- African Americans are more than three times as likely as Caucasians to die from HIV/AIDS, while Hispanics are more than 1.5 times more likely to die from the virus.
- The rate of tuberculosis for Asians is more than 15 times greater than it is for Caucasians.
- African Americans are more than three times as likely to die from diabetes as Caucasians; the death rate for American Indians/Alaska Natives is 2.5 times higher and for Hispanics it is 1.5 times higher.

Disparities affecting racial and ethnic minorities can be observed for 18 of 24 disease conditions in the 1996 Department of Health report *Health of Washington State.* Epidemiological data for those 24 conditions show that African Americans have a disproportionate disease burden for 18 conditions; American Indians for 16 conditions; Hispanics for 11 conditions; and Asian/Pacific Islanders for three conditions.

Many complex factors interact to produce health disparities. Risk factors believed to contribute include poverty, behavior and lifestyle, nutrition, environment, access to health care services, genetic predisposition, education, and employment. Research by Public Health—Seattle & King County found that for people of color, racism or the perception of racism in health care settings is also a barrier.

Research shows a diverse health care workforce can improve the health status of racial and ethnic minorities. During the 1999-2001 biennium, the Board showed that people of color are underrepresented in our state's health care workforce and underserved by its health care system. Its final report identified multiple opportunities to build a more diverse health care system, including recruitment and retention programs that serve students of color (and help alleviate critical workforce shortages).

The key informants interviewed by State Board of Health staff and the people who responded to the online survey overwhelmingly supported the Board's past work on health disparities and said some form of health disparities work should continue. When asked to rate items on the Board's list of possible priority projects, continuing to work on health disparities scored highest across all groups.

Suggested foci for future work included: continue efforts to increase workforce diversity; examine racism in health care settings; research affordability of care, provider access, and insurance availability for the poor and for communities of color; develop effective interventions for specific disease conditions within affected communities.

The federal government has emphasized the latter approach. *Healthy People 2010* objectives call for achieving parity in cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, immunizations, and infant mortality across racial, ethnic, gender, and socioeconomic groups.

A 'For Instance'

Increased Diversity Within the Health Care Workforce

The State Board of Heath *2001 Final Report on Health Disparities* describes the growing body of research that shows that a diverse health care workforce can improve the health status of racial and ethnic minorities. It also documents the degree to which people of color are underrepresented in the health care workforce.

Increased recruitment of people of color into health professions will also help address shortages in many health professions. *Who Will Care for You?*, a Washington State Hospital Association and the Association of Washington Public Health Districts report, shows that shortages threaten quality of care for everyone, and cites lack of diversity as a contributing factor.

The Board report makes six recommendations, many of which will require continued work during 2003-05. They are:

1. Enumerate the composition of the health care workforce

2. Establish guidelines for health career development programs

3. Facilitate training and credentialing of people with prior health care experience, including foreign-trained and mid-career professionals

4. Create a Graduate Medical Education incentive pool

5. Develop a health care workforce diversity report card

6. Coordinate health care workforce diversity efforts through a public/private panel

Other Possible Actions

- **Indian Health Initiatives:** Recognize and support leadership in Indian health and health policy and develop opportunities to work collaboratively with American Indian leaders, communities, and organizations.

- **Cultural Competency:** Work with provider groups, health care facilities, health professional schools, and health care and public health organizations to ensure the health care workforce has the skills needed to work with diverse populations.

- **Academic Enrichment/Career Development:** Aggressively pursue additional federal grants and private funding for programs that prepare students of color for future academic success and encourage them to pursue health careers.

- **Childhood Obesity:** Childhood overweight and obesity is particularly endemic to Hispanic and African American populations, affecting 22 percent of all children in both groups, compared to a still problematic 12 percent of white children. Intitiatives concerning diet and activity (see next page) should address obesity in culturally appropriate ways.

- **Diabetes Collaborative:** Continue work of public/private cooperative focusing on implementing quality improvement of clinical management of diabetes. Diabetes is the seventh leading cause of death and is much more common in African Americans and Hispanic Americans. American Indians, Alaska Natives, and African Americans have higher rates of diabetes-related complications such as kidney disease and amputations.

- **Provider Incentives:** Create incentives, such as scholarships and loan foregiveness, for nurses and other providers who agree to practice in areas where the proportion of minority health care workers is lower than the minority population (similar to existing programs for providers in underserved rural communities).

Encourage responsible behavior to reduce tobacco use, improve nutrition, and increase physical activity

Summary

About 50 percent of our health is determined by our behaviors. The behaviors most damaging to our health are tobacco consumption and the interrelated behaviors of insufficient physical activity, poor diet, and inadequate nutrition.

A study of "Actual Causes of Death in the United States" in 1990, published in the Nov. 10, 1993 *Journal of the American Medical Association*, found that tobacco accounted for 400,000 out of roughly 2 billion deaths that year. Diet and activity patterns accounted for another 300,000. Combined, they explained about a quarter of all deaths. No other cause accounted for more than 5 percent.

Healthy People 2010, the federal government's strategic plan for health improvement, lists "physical activity" and "overweight and obesity" as its top two health indicators, followed by "tobacco use."

When asked to rate the seriousness of various health issues in the Board's 1997 public opinion survey, respondents listed, in order, "misuse of alcohol and other drugs," "lack of exercise and poor eating habits," and "tobacco use and secondhand smoke" (tied with "sexually transmitted diseases").

Tobacco use received a few mentions in the Board's key informant interviews and the on-line survey responses, largely because respondents considered tobacco cessation to be a Department of Health effort. Obesity, however, was one of the items mentioned most often. Local community health assessments have also identified tobacco use and obesity as important issues.

Tobacco Use

In 1997, 36 percent of all adolescents and 24 percent of all adults in the United States were smokers. Deaths from tobacco use cost the nation an estimated $50 billion per year. The 2000 Behavioral Risk Factor Surveillance System (BRFSS), which reports statewide prevalence of risk factors, reports that more than 22 percent of Washington's total population currently smokes and that between 1999 and 2000 the smoking rate increased. The Department of Health's *Washington State Vital Statistics* report states that half of all pregnant women smoke during pregnancy. In King County, tobacco use has increased, especially for people younger than 18.

Diet and Physical Activity

The media have given significant coverage in the last few months to the rise in obesity and, as a result, the increasing incidence of diabetes. They have also covered in some depth the controversy around the sale of candy and soft drinks in school cafeterias.

Most health trends, nationally and in Washington, are moving in the right direction. One of the few exceptions is obesity. Americans are getting fatter. According to the most recent National Health and Nutrition Examination Survey, the number of overweight children and adolescents has nearly doubled in 20 years. Health leaders such as Dr. Jeffrey Koplan, director of the Centers for Disease Control and Prevention, and Surgeon General David Satcher have called obesity an national epidemic. Conditions related to obesity and overweight add $117 billion annually to the nation's health care bill.

According to the 2000 BRFSS, 73 percent of the total Washington population does not engage in "regular or sustained" physical activity during one month. More than 83 percent does not engage in "regular or vigorous" physical activity during one month. About 55 percent of the total state population is overweight or obese.

On average, higher body weight is associated with higher death rates. Diabetes, which is linked to obesity, has consistently been the sixth or seventh leading cause of death in this state during the 1990s. During that time, the percentage of all deaths resulting from it has risen slowly.

A 'For Instance': Diet and Activity

Development of Effective Health and Fitness Assessments

On December 13, 2001, Surgeon General David Satcher suggested that the number of premature deaths caused by weight-related illnesses may soon surpass the number caused by smoking. Dr. Satcher suggested steps to address the problem, many of which concerned diet and exercise in schools.

Washington State has included an Essential Academic Learning Requirement for Health and Fitness as part of the Washington Assessment of Student Learning (WASL). All Washington schools are currently required to teach Health and Fitness. Health and Fitness assessments are being developed for the classroom that would measure whether a student has the skills necessary to maintain an active and healthy life. Health and Fitness assessments will be available for voluntary use during the 2005-06 school year. They will become mandatory during the 2008-09 school year.

Other possible schools-related initiatives would be to provide more healthy food choices for students and to explore options for restricting student access to vending machines serving calorie-dense snacks and soft drinks.

A 'For Instance': Tobacco

Successful Implementation of Tobacco Prevention and Control

Eighteen months ago, Washington launched its first comprehensive program to prevent youth from becoming addicted to tobacco, and to help adults quit smoking. A variety of initiatives have begun:

- A statewide media campaign that focuses public attention on the dangers of tobacco use—90 percent of youth polled had recently seen an anti-tobacco ad on television
- A telephone tobacco Quit Line that has provided free counseling and assistance to more than 13,000 tobacco users
- Local, tribal and school anti-tobacco programs
- OutrageAvenue, a Web site that engages youth in the fight against tobacco use (visit www.OutrageAvenue.com), which had more than 237,000 hits in the first nine months.
- Reduced sales of tobacco to underage buyers through a contract with the Liquor Control Board.

For 2003-05, continue the use of money from the tobacco settlement funds for tobacco prevention and control programs designed to prevent children from getting addicted to tobacco and helping users quit.

New elements might include: establish a youth quit line and a quit line Web site; train Maternity Support Services staff to counsel clients about quitting tobacco and reducing secondhand smoke in homes; continue the media campaign with advertising created specifically for Washington; and evaluate the program's media campaign, cessation program, and school and community-based programs.

Background

The Washington State Constitution promised the people that their state government would provide for public health and welfare. It established the Washington State Board of Health to help lead this effort.

Since 1989, one responsibility of the Board has been to produce the State Health Report. RCW 43.20.50(1)(b) stipulates that the report be produced in January of even numbered years and that it serve as an aid to the Governor at the beginning of the budget process by suggesting health priorities for the ensuing biennium. RCW 43.20.50(1)(b) further stipulates that the Governor must approve, modify, or disapprove the report. If approved, the report is to be used by state agency administrators as a guide for preparing agency budgets and executive request legislation—in this case, for the 2003-2005 biennium.

This is the sixth report prepared by the Board, and it differs from prior iterations in several respects. Those differences concern both the process and the final product.

Statute defines the minimum process required. The Board is required to hold public forums every five years and to consider public input gathered at those forums in the preparation of the report. The Board is also required to consider the best data available from the Department of Health and the Department is required to submit a list of high-priority study issues. Finally, the Board must ask for the assistance of local health jurisdictions and consider input from the directors of state health care agencies.

In preparation for this report and to help it establish its own priority projects for 2001-03, the Board held a series of public forums in 2000 and Board staff conducted extensive research in the spring of 2001. The research phase had two major components—a literature review, which included an examination of the best available data from the Department of Health, and key informant interviews. Finally, the Department provided a memo dated July 5, 2001 that described high-priority study issues.

For the literature component of the Board's research, Board staff reviewed more than 40 print and electronic documents, including federal and state government reports, articles from scientific and medical journals, policy analyses published by foundations and other nonprofit organizations, public opinion surveys, and local health assessments. Staff members prepared a document called the "survey of surveys" that summarized the findings. The Board asked the University of Washington's Northwest Center for Public Health Practice (NWCPHP) to review the document, and the reviewers found it to be very complete.

For the qualitative survey portion of the research, Board staff assembled a list of key informants with expertise in health policy formation and implementation from around the state. The list included two groups whose input is required by statute—officers from local health jurisdictions and the heads of state health care agencies. They also included legislators, legislative staff, congressional staff, agency directors, gubernatorial policy staff, directors of minority affairs commissions, deans at public health and medical professional schools, policy directors of professional and industry associations, and directors of health advocacy organizations.

The Board contracted with the NWCPHP to interview the state's key medical and public health faculty, many of whom were already on the key informant list. Board staff members then divided the list of the remaining key informants and conducted interviews with all informants who were available to participate. Combined, NWCPHP and Board staff interviewed 52 key informants. Additionally the Board posted on its Web site a survey instrument based on the script used for the key informant interviews. Twenty-three people completed and submitted the survey.

Both the survey and the interview script focused on the Board's priorities, but they also provided opportunities for the respondents to speak to what they thought were the health priorities facing the state.

The findings from the key informant interviews, the Web-based questionnaire, and the survey of surveys have been incorporated into a July 2001 staff report, *Research on Board of Health Priorities*. The full report is available from the Board's office or on its Web site, www.doh.wa.gov/sboh/.

Revamping and expanding the research that undergirds the report is the first of two significant process changes between this report and the last. The other change acknowledges the important role of the newly created Governor's Subcabinet on Health. Established in January 2001 by Executive Order 01-02, the Subcabinet is charged with developing and coordinating state health care policy and purchasing strategies, providing a forum for the exchange of information between agencies, and coordinating efforts to provide appropriate, available, cost-effective, quality health care and public health services to the citizens of the state.

The Board feels there are clear synergies and areas of complementary responsibilities between the Board and the Subcabinet. Many members of the Subcabinet are the very agency heads with whom the Board is required to consult, and to be effective, the health priorities put forth in this report should align with the goals and intent of the Subcabinet.

To promote consistency and avoid duplication of effort, the Board worked closely with representatives of the Subcabinet in the development of this report. Board staff members drafted this report in close consultation with both the full Board and a working group that comprised the executive director of the Board, the chair of the Subcabinet and administrator of the Health Care Authority (HCA), the health policy adviser from the Governor's Office of Executive Policy, and senior policy analysts from the Board and HCA.

Board staff members have also consulted with key members of the Subcabinet and relied heavily on the priority-setting work of the Washington State Health Agency Medical Directors group (AMD), which supports the Subcabinet's work. AMD enhances collaboration across agencies and seeks to "identify and assess new opportunities for state agencies to increase quality, and to promote cost effectiveness, access, and affordability in the state's medical care financing and delivery system." It proposed a prioritized list of interagency projects to the Subcabinet.

In addition to changes in the process leading up to this report, there have been significant changes in the final product—the content of the report itself. Past reports have been lengthy (80–120 pages) and have included, in addition to a fairly broad list of health priorities, extensive research findings, lists of priority study projects, examples of recent successes, and comprehensive listings of action strategies for nine health-related agencies.

This year, the Board and Subcabinet representatives have agreed to feature a limited number of *strategic* policy directions. This approach is consistent with RCW 43.20.050(1)(b) since it provides agency heads with an outline of state health priorities. The strategic directions proposed in this report are not all-inclusive, nor are they meant to be prescriptive. State agencies provide numerous health-related services that are not covered by these strategic directions, but are important and appropriate. Rather, these strategic directions suggest areas of emphasis—areas where state efforts to create new activities or preserve existing activities are most likely to be effective.

Furthermore, this report does not attempt to identify recommended action strategies for the 2003-05 biennium. The statute does not call for that level of detail and Board and Subcabinet representatives concur that decisions about specific programs should be made by agency heads coordinating their efforts through the Subcabinet.

For each strategic direction, this report contains a summary of why it is included, a "for instance" that describes one example of an initiative deserving further consideration, and a list of possible actions that illustrate the scope of the strategic direction.

About the Washington State Board of Health

The State Board of Health serves the citizens of Washington by working to understand and prevent disease across the entire population. Established in 1889 by the State Constitution, the Board provides leadership by suggesting public health policies and actions, by regulating certain activities, and by providing a public forum. The governor appoints ten members who fill three-year terms.

Board Members

Consumers

Linda Lake, M.B.A., Chair, has 25 years of experience in the field of health and social services. She has directed several community health and social service organizations, including the Pike Market Medical Clinic.

Joe Finkbonner, R.Ph., M.H.A., is director of the EpiCenter at the Northwest Portland Area Indian Health Board and has served as chair of the American Indian Health Commission.

Elected County Officials

The Honorable Neva J. Corkrum, Vice Chair, is a Franklin County commissioner and member of the Benton-Franklin Health District Board of Health.

Elected City Officials

The Honorable Margaret Pageler, J.D., is a member of the Seattle City Council and serves on the Board of Public Health in Seattle and King County.

Department of Health

Mary Selecky is secretary of the Washington Department of Health and former administrator of Northeast Tri-County Health District.

Health and Sanitation

Charles R. Chu, D.P.M., a practicing podiatrist, is president of the Washington State Podiatry Independent Physician Association.

Ed Gray, M.D., is health officer for the Northeast Tri-County Health District and chair of the Basic Health Plan Advisory Committee.

Carl S. Osaki, R.S., M.S.P.H., former director of environmental health for Public Health—Seattle & King County, is on the faculty at the University of Washington.

Vickie Ybarra, R.N., M.P.H., is director of planning and development for the Yakima Valley Farm Workers Clinic. Much of her work is dedicated to supporting children and families.

Local Health Officers

Thomas H. Locke, M.D., M.P.H., is health officer for Clallam and Jefferson counties and medical director of the Port Gamble S'Klallam tribal health program.

Board Staff

Don Sloma, M.P.H., Executive Director

Craig McLaughlin, M.J., Senior Health Policy Manager

Doreen Garcia, M.P.P., Senior Health Policy Advisor

Marianne Seifert, M.A., Health Policy Advisor

Desiree Day Robinson, Executive Assistant to the Board

Jennifer Dodd, Assistant to the Board

2002 Washington State Health Report

The Washington State Board of Health and Ida Zodrow, chair of the Governor's Subcabinet on Health, submitted this document to Governor Gary Locke, who approved it on May 6, 2002.

For Additional Copies or More Information

For additional copies or more information, contact the Board staff or visit the Board's Web site:

1102 SE Quince Street
PO Box 47990
Olympia, WA 98504-7990
Telephone: 360 236-4100
Fax: 360 236-4088
E-mail: wsboh@doh.wa.gov
Web: www.doh.wa.gov/sboh/

For people with disabilities, this document is available in other formats on request.

Washington State Board of Health

1102 SE Quince St.
PO Box 47990
Olympia, WA 98504-7990

Telephone: (360) 236-4100
Fax: (360) 236-4088
E-mail: wsboh@doh.wa.gov
Web: www.doh.wa.gov/sboh